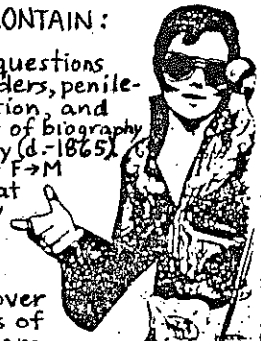
Rites Of Passage

MAGAZINE OF FEMALE-TO-MALE TRANSSEXUALS & CROSSDRESSERS

16 PAGES FULL OF IMPORTANT INSIDE INFORMATION IN EACH ISSUE!

THE 2 CURRENT ISSUES CONTAIN:



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I am: ☐F→M T/S ☐F→M C/D

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STREET: _____

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(our non-profit group is in desperate need of funds)

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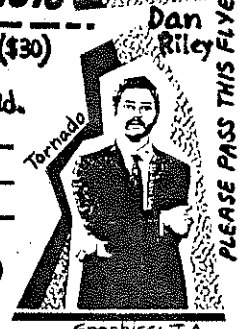

Graphics: J.A.

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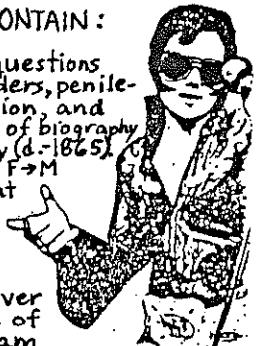

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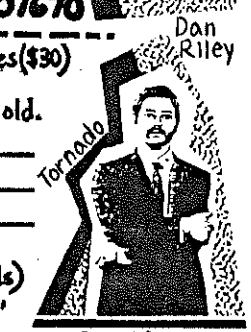

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In the future: Info. on: Hormone Injections; Phalloplasty; Genitoplasty.
Cover Stories about: Lou Sullivan & "Tornado." Frank on Sally Jesse!

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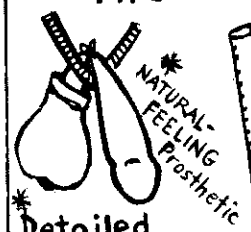
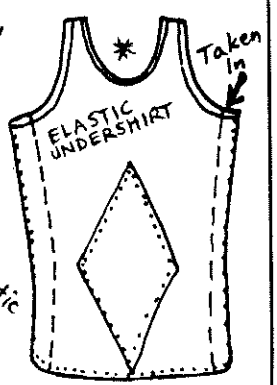
"PASSING" TIPS



* Detailed Instructions Pages 7-8



F2M

INTERNATIONAL, NON-PROFIT,
PEER-SUPPORT NETWORK
FOR FEMALE-TO-MALE
TRANSSEXUALS AND CROSS-DRESSERS

CONTACT: JOHN A.; % S.G.; P.O.B. 615; TENAFLY, N.J. 07670

DEAR COMRADES:

PLEASE FORGIVE THE DELAY OF THIS REPLY! WE WERE ABSOLUTELY OVERWHELMED BY A MOUNTAIN OF INQUIRIES, WHICH CAUSED US TO LAG OVER SIX MONTHS BEHIND ON OUR RESPONSES!

"**F2M**" IS AN INTERNATIONAL SUPPORT-GROUP OF FEMALE-TO-MALE TRANSSEXUALS AND CROSSDRESSERS. WE HAVE REGULAR MEETINGS IN NEW YORK CITY; AND WE'RE HELPING OUR MEMBERS ORGANIZE LOCAL MEETINGS IN OTHER FAR-FLUNG AREAS. WE ALSO MAINTAIN A WIDE-SPREAD POSTAL NETWORK, WHICH IS BEING COMPILED INTO A CONFIDENTIAL CONTACT LIST.

WE URGE OUR MEMBERS TO FORM SUPPORT-GROUPS BECAUSE IT IS INVALUABLE TO MEET AND SHARE OUR EXPERIENCES. WHETHER YOU'RE JUST STARTING OUT AT CROSSDRESSING, OR A POST-OP T/S OF 10+ YEARS, YOU <u>WILL</u> BENEFIT FROM THE WONDERFUL FEELING OF TOTAL UNDERSTANDING, AND UNCONDITIONAL ACCEPTENCE THAT WE ALL EXPERIENCE IN A ROOM FULL OF 15-20 "BRO.S", WHO ALL SHARE A UNIQUE SECRET. AND THANKS TO STRICT CONFIDENTIALITY, AND ANONYMITY (Y)OUR SECRET <u>REMAINS</u> A SECRET!

WE HAVE NO MEMBERSHIP FEE. ALL YOU NEED TO DO TO JOIN, IS SEND US A SELF-ADDRESSED STAMPED ENVELOPE, AND WE'LL SEND YOU MORE INFO. AND A MEMBERSHIP FORM. WE'VE MADE IT VERY EASY TO BECOME A PART OF OUR GREAT FRATERNITY. SO, **PLEASE** JOIN US (REGARDLESS OF YOUR OTHER ORGANIZATIONAL AFFILIATIONS), AND HELP US CREATE A BROAD-BASE OF MEMBERS, AND TO PROVIDE A FIRM FOUNDATION OF SUPPORT & BROTHERHOOD.

WE TAKE GREAT PRIDE IN "BEING THERE" FOR YOU. MEMBERS CAN GET UNLIMITED <u>FREE</u> TELEPHONE COUNSELING! YOU CAN CALL THE **F2M HOTLINE**, 24 HOURS A-DAY, 7 DAYS A-WEEK. YOU WILL ALMOST ALWAYS GET OUR KNOWLEDGEABLE & SYMPATHETIC COUNSELOR (JOHNNY ARMSTRONG), BUT OCCASSIONALLY YOU MAY HAVE TO LEAVE A MESSAGE.

SO YOU DON'T HAVE TO BE ISOLATED OR UNINFORMED ANY LONGER! WE CAN ANSWER ALL OF THOSE IMPORTANT QUESTIONS, AND PROVIDE YOU WITH THE INFORMATION THAT IS SO **ESSENTIAL** TO THE DECISION-MAKING PROCESS. UNBIASED COUNSELING WILL HELP YOU SORT OUT YOUR INDIVIDUAL PRIORITIES, AND FIND THE BEST ANSWERS FOR YOUR INDIVIDUAL SITUATION.

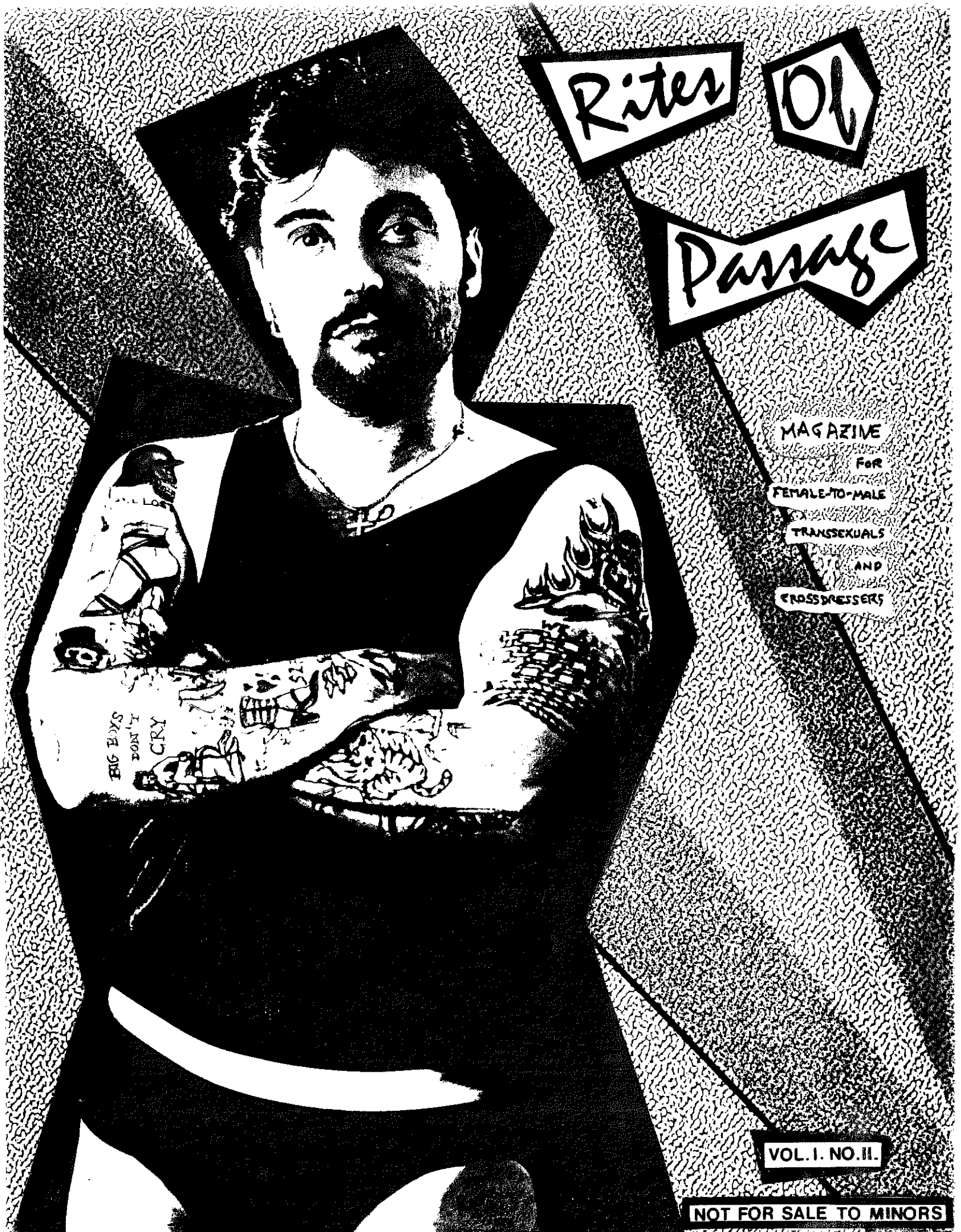
WRITE SOON... <u>WE</u> NEED <u>YOU</u>, AND YOU NEED US.

LOOKING FORWARD TO HEARING FROM YOU...

SEND EXTRA STAMPS
IF YOU CAN
FOR FUTURE MAILINGS

The United Brothers of the F→M

Fraternity


Rites Of Passage
MAGAZINE FOR FEMALE-TO-MALE TRANSSEXUALS AND CROSSDRESSERS
BIG BOYS DON'T CRY
VOL. I. NO. II.
NOT FOR SALE TO MINORS

DEAR FRIENDS: 12·89

WELCOME TO OUR SECOND ISSUE!

THIS MAGAZINE IS BROUGHT TO YOU BY THE MEMBERS OF "F2M", THE WORLD-WIDE, NON-PROFIT, SUPPORT NETWORK FOR FEMALES-TO-MALES.

THIS ISSUE IS MUCH MORE VISUALLY STIMULATING THAN OUR FIRST ISSUE, THANKS TO THE CONTRIBUTIONS (AND OPENESS) OF SOME OF OUR MEMBERS.

WE INVITE YOU TO CONTACT US... PLEASE TAKE A FEW MOMENTS TO WRITE TO US, HOWEVER BRIEFLY. WE <u>REALLY</u> <u>NEED</u> <u>YOUR</u> FEEDBACK TO KEEP US GOING.

AND, DON'T FORGET, THIS COMMUNICATIONS NETWORK EXSISTS TO HELP <u>YOU</u>, SO IT'S IN YOUR BEST INTEREST TO HELP THE NETWORK SURVIVE!

HOPEFULLY, THE ENCLOSED INFORMATION WILL REACH THOSE WHO NEED IT. KNOWLEDGE IS THE KEY TO DEALING WITH GENDER DYSPHORIA. THE ANWERS ARE OUT THERE, WE CAN FIND THEM... TOGETHER.

YOURS, IN SOLIDARITY,

John Armstrong

EDITOR

"RITES OF PASSAGE" MAGAZINE IS PUBLISHED AT IRREGULAR INTERVALS. THE COST OF A SUBSCRIPTION IS $32 FOR 8 ISSUES, OR $4.50 PER ISSUE ON THE NEWSTAND.

WE OFFER THIS MAGAZINE, THROUGH THE MAIL, ON A SLIDING SCALE, SO THAT IT IS AVAILABLE TO ALL F.M. T/S's & C/D.'s, REGARDLESS OF ABILITY TO PAY. IF YOU CANNOT AFFORD THE RETAIL PRICE, DON'T HESITATE TO REQUEST A COPY.

IF YOU WOULD LIKE TO PLACE A PROFESSIONAL OR PERSONAL AD, PLEASE SEND US YOUR AD COPY, AND WILL WILL SEND YOU A PRICE.

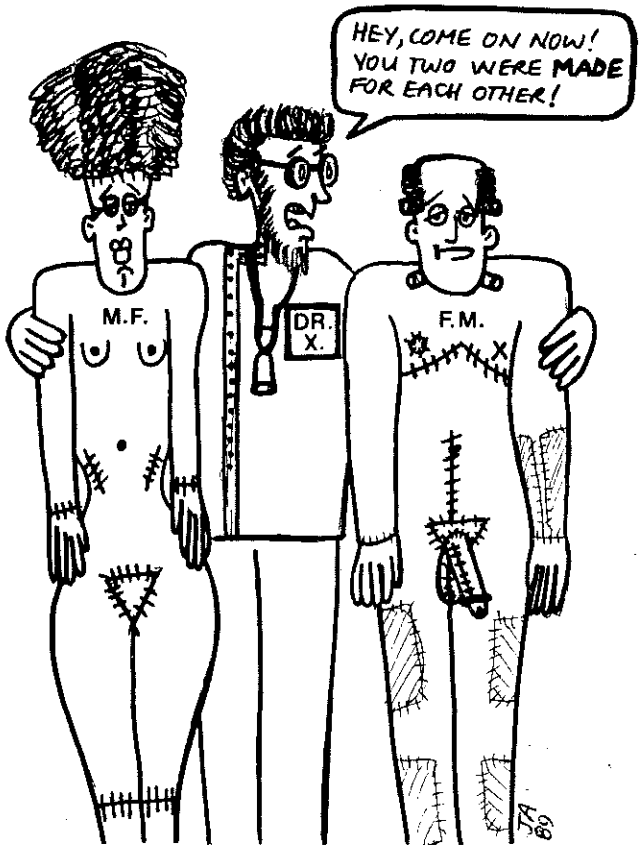
WRITE TO: F2M
POB 135
Edgewater, NJ 07020 ~~FLY, NJ~~

OR CALL: (212) 725-1289 ext. 326 (ANYTIME)
A MACHINE (JUST MUSIC) WILL ANSWER AT ALL TIMES, 24-HRS A-DAY.
WHEN YOU GET THE MACHINE, ASK FOR JOHN ARMSTRONG AND IDENTIFY YOURSELF, IF WE'RE HOME, WE'LL ANSWER; IF NOT LEAVE YOUR NAME AND NUMBER, AND WHETHER OR NOT WE CAN CALL YOU BACK COLLECT.

VOL. 1. NO. 11. DECEMBER 1989

NOT FOR SALE TO MINORS

IN UPCOMING ISSUES WE'LL BE BRINGING YOU INFORMATION ABOUT:
CROSS-DRESSERS: "TORNADO", SHELLY MARS, AND SANDE ZEIG.
PHALLOPLASTY- PROS & CONS.
A TRIBUTE TO LOU SULLIVAN, F/M Leader.
HORMONE INJECTIONS - DOSAGE & EFFECTS.
GENITOPLASTY- PERSONAL EXPERIENCES.
PLAUTO'S PHOTOS OF F/M T.V.S.



members (internationally) and we are growing slowly and steadily. But even if you can only find one or two brothers in your locale, that friendship will prove invaluable (provided you totally respect each other's confidentiality and anonymity). With a little effort and initiative you will find your fraternity ... but that means getting off your butt, and throwing away your fear of reaching out! It's hard to trust others with your secret; but peers CAN be trusted because we all have an equal stake in not being "revealed". It's not a matter of risking a career or relationships ... it is the integrity of our very identity that is at stake.

On a personal note ... when I first discovered that gender-reassignment was possible for genetic females (about 4 1/2 years ago), I knew immediately that it was the answer to my prayers. I had been living as a man (without hormones) for many years. I had no knowledge of Dr. Benjamin's "Standards of Care", but I came up with what I felt would be my best course of action. I decided that (#1) I should go into therapy with a gender-specialist (and be totally honest about everything), just to be sure (as if there was ever any question!!). (#2) I would have to meet others like me, and find out the inside story. (#3) I would start taking hormones. (#4) I would have surgery.

I felt it would be absurd to begin such a serious undertaking without meeting a few people who had already been through it all. Well ... it took me almost two years to find a gender-specialist and an F/M organization (which was in Canada!), three years to start hormones, and about four years to have a peer-support group to go to (which I had to create myself!). In that four years, my need to meet and learn from my brothers became so great that I have been making myself available by telephone (and mail) to provide virtually unlimited free peer-counseling. And, I KNOW that I get almost as much out of counseling my peers, as they get from being counseled.

So ... I am hereby extending this personal invitation to each individual brother out there (regardless of any other organizational affiliations you may have) to join "F_2M". It's free, if you can't afford to contribute. As anonymous individuals hiding behind our macho fears we have little power, but as a large group of anonymous individuals we can lobby politically and use our leverage to influence/enlighten helping professionals and others, as well as getting merchandisers to give our members a group discount. Also, hopefully in the near future our non-profit status will become official.

Finally, let me share some of the insight I have gained, concerning those issues that seem to be of greatest interest to us.

Our most crucial issues involve how to make informed decisions concerning the complex and mystifying fact/fiction of surgery. In particular, phallo- and genitoplasty, but also chest contouring (creation of a masculine chest as opposed to standard female mastectomy), and hysterectomy (requiring special surgical methods). We are also concerned with identifying "butchers" and "chop shops".

Our other favorite subjects are: (a) the long term effects of testosterone therapy (and whether or not pills are safe); (b) how to initiate and establish intimate (sexual) relationships; and (c) the importance (or unimportance) of possessing a penis (functional or otherwise).

I hope that my words will stir your thoughts and that you will grab a pen and jot down some notes (however brief) asking your own personal questions and expressing your feelings on the issues I've discussed; safe in the knowledge that your privacy will be fully protected.

Yours in brotherhood, John A.

Sonny: Age 9

F.T.M. COMPILATION VIDEOTAPE
ONLY $6 FROM L. SULLIVAN
1827 HAIGHT STREET
SAN FRANCISCO, CA. 94117

This wonderful video contains footage of: "John and Susan", Steve Dain, Nick Detullio, Steve Roczey, Dr. David and Debbie Gilbert, Dr. Paul A. Walker, Dr. Ira Pauly, Dr. Terrence Malloy, and Vanessa Redgrave as Renee Richards

* THIS ARTICLE WAS REPRINTED FROM TAPESTRY MAGAZINE.

F$_2$M

(John Armstrong is a peer-counselor, working with female-to-male TSs and CDs. He is the editor of the F/M newsletter "Rites of Passage" and is the founder of "F2M", the international, nonprofit anonymous support group based in New York City. John is actively seeking your comments and questions. You may write to him ~~c/o S.G., P.O. Box 615, Tenafly, NJ 07670 or call him at (201) 224-7843~~. All communication is strictly confidential.) F2M/POB 135/Edgewater, NJ 07020

F-M FRATERNITY

by John Armstrong

"Brothers United" ... (or) ...
"He Ain't Heavy, He's My Brother"

It is my deeply held belief that our emotional (and often physical) well-being depends on the availability of personal interaction with others like ourselves. It is very beneficial to network, meet, and share our experiences, face-to-face.

For those of us who are pre-op (trying to find the right path), it is essential for educated decision-making. We desperately need to meet those who have gone before us. We need to hear the truth about surgery, therapy, costs, etc. (as opposed to the sugar-coated story that surgeons sell).

For our post-op brothers who are so well-hidden in society, anonymity is absolutely **required**. After surgery we are no longer transsexuals; we have become men. The post-op's hard-won manhood MUST be protected, but this should not stop us from meeting and communicating with our peers (as long as anonymity and confidentiality are assured). Even a post-op "lone wolf" will benefit from the unconditional love that exists between brothers who share the same traumatic beginnings.

For all of us, (post-op AND pre-op) our quality of life requires that we be perceived solely as genetic males, and we must disown our transsexuality to achieve this. "Disown" means two things: (a) To refuse to acknowledge as one's own; and (b) to reject all connection with.

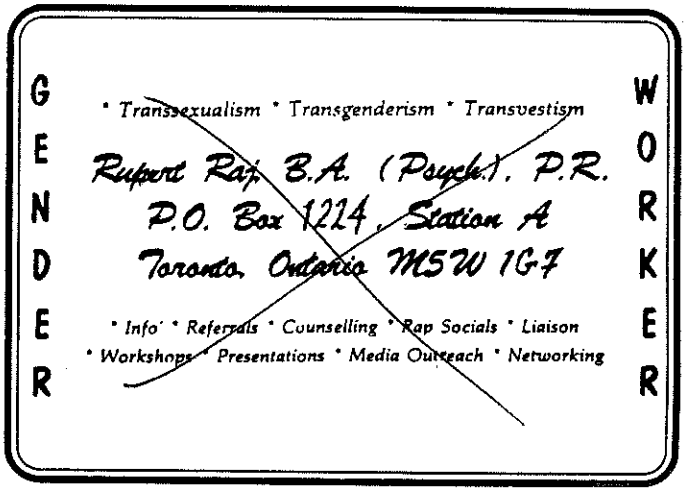
The problem is, that this is a form of denial. Because we must deny our former gender-status to the world, it becomes essential for us to find some small, "safe" time and space where (for a few moments) we can quietly share our hidden thoughts and questions.

Because of the struggle we face, we undoubtedly have many important feelings. Because we were socialized as female, we usually have a strong need to express these feelings. Because we are men, we may have great difficulty "opening up". It often seems that we cannot (indeed, perhaps we SHOULD not) open up completely to any one who is not a peer. No one understands and emphathizes like a brother; and whether we admit it or not, we all NEED understanding.

If you have never been in a room full of anonymous (safe) brothers, sharing that incredible sense of acceptance and positive self-affirmation, you owe it to yourself to try it.

You will have to seek it out, though. It's not easy to find such a group. The only fairly large groups I know of are "F$_2$M" on the east coast and "**FTM**" out west. But there are smaller groups out there (including Philadelphia and Massachusetts).

It took me more than three years of aggressive outreach to get "F$_2$M" going. We now have about thirty


GENDER
WORKER
• Transsexualism • Transgenderism • Transvestism
Rupert Raj, B.A. (Psych.), P.R.
P.O. Box 1214, Station A
Toronto, Ontario M5W 1G7
• Info • Referrals • Counselling • Rap Socials • Liaison
• Workshops • Presentations • Media Outreach • Networking

TAKARAZUKA

☆ TAKE NOTE, ALL YOU FANS OF F.-TO-M. CROSSDRESSING and/or BUSBY BERKELEY... WATCH OUT FOR **TAKARAZUKA**. THIS ALL-FEMALE THEATRICAL TROUPE IS KABUKI GONE VEGAS, WITH WOMEN PLAYING ALL THE MALE ROLES, INCLUDING THE ROLES OF MEN IN DRAG!

Takarazuka was founded in 1914 by Japanese businessman Ichizo Kobayashi, who owned a Disneyland-like amusement park and thought theater should be a part of the entertainment experience. Since Japan's classical Noh and Kabuki theater used all-male casts, women having no place in the theater, Kobayashi, as an attempt to modernize, did the opposite and hired all women.

In Japan the leading performers are idolized, with a celebrity status equal to America's most popular movie stars. To the teenage girl groupies who crowd their shows screaming affection, they are the equivalent of the rock group Menudo. But their training is more in the Japanese style. Fifteen- to eighteen-year-old girls enter a rigorous training program where they are molded into members of Takarazuka. Guided by their motto "Modesty, fairness and grace," they attend classes in acting, singing and dancing, and the first-year students are required to spend an hour a day cleaning the school, including the toilets.

Takarazuka will perform at Radio City Music Hall from October 25th to 29th. As part of their program, the troupe's "male" star will sing "A Pretty Girl Is Like a Melody" in English, accompanied by female show girls in ornate gold costumes with white feathers. In another segment, a beautiful lady flashing a pink feather fan will step out of a huge makeup compact to sing "You Stepped Out of a Dream." Other numbers will include "Arabian Dreams" and "I Only Have Eyes for You."

She's queen of The King lookalikes

WHEN Elvis Presley impersonator Stoney Jones gets on stage, The King comes alive again. But there's a catch – Jones' first name is really Linda!

She may be the only female Elvis act in the country. "Everyone gets all shook up when I perform attired in full Elvis regalia. Much of audience doesn't know how to react," says the celebrity lookalike who hails from Ill.

"I lip-sync Presley's songs and my band backs me up. People say my show is one of the most realistic portrayals of Elvis they've seen. Not only do I physically look like Elvis on stage, but I've been a fan of his for as long as I can remember." □

ANDROS

"ANDROS" is the pen-name of our bright, young columnist from Pennsylvania. Andros is a genetic female, who identifies as transgendered. He will be bringing us his very interesting insight, on a regular basis.

Essay #1- ACCEPTING THE ANIMA:Coming to Terms with the feminine side of myself.

As a young child I knew that I was a boy. With the innocence and honesty of a child, I knew my feelings. I also sensed the rejection of my feelings by others I knew I should keep it to myself; yet the feelings were strong enough that I was compelled to act upon them. I shunned girls' toys and activities, so as to be the BEST little tomboy that I could be. I openly rejected gifts of dolls, tea-sets and sewing notions--though I had the good sense not to let on that I was doing so because I was a BOY. As it was, they were none to pleased with my ingratitude.

In later years, without giving much thought to it, I would turn my nose up at "feminine" activities: cooking, cleaning, sewing, gardening and appreciating nature. My mother made me do most of these things, so in my mind they were not only associated with femininity, but also with being coerced and humiliated (which was my mother's way of "asking" me to do something). I came to resent these activities and as soon as I was out of the home--away at college--I happily avoided them.

I found that I had to make a few concessions, however. I discovered that food would not cheerfully leap onto my plate, fully prepared and seductively inviting me to devour it. I learned that I had to cook my own food. I rationalized cooking, as a necessity. Likewise for cleaning house and doing laundry; the filth was piling up beyond even my tolerance. Oh the joys of bachelorhood!

A few years ago (I am nearing my thirty-first birthday) I began to actually enjoy doing the "feminine" activities listed above. I prided myself for years on being a feminist, yet, piglet that I was,I had contempt for "feminine" activities. Then I learned to tolerate them, out of necessity, and finally enjoy them.

When I went through some very intense (primal) therapy, I released a great deal of sexual guilt and with that, shame for being"female". For two years I lived as a woman, and even enjoyed some of it (other than the sex and the discrimination). It was at that time that I began to enjoy cooking, flowers, stuffed animals and other "feminine things. Underneath it all though, I realized that I still had, a predominantly MALE gender-identity.

So I'm left with a dilemma...now I must come to terms with both sides of me--and I must decide which gender to be. Even if I do go through sex-reassignment, I don't want to stifle my "other side", as I had to do when I was a child.

It may not be socially acceptable for a man to collect stuffed-animals or arrange flowers--but neither is transsexualism socially acceptable. Can I be man enough to do what I want? I have two years of machokarate training to be able to back it up when I say:"Hey,pal, I want to study ballet...got a problem with that?!"

HE/SHE WAS THE MAN/WOMAN OF HIS/HER DREAMS.

ANOTHER F-M NEWSLETTER IS BORN

"Adam's Word" is a new monthly newsletter published by The Adam Society, a nonprofit support groupfor female-to-males and their significant others in the New England area. The first issue(August 1989), one 8-1/2X11" page printed on both sides relied heavily on reprinted material from FTM. Subscriptions are $10 for 12 issues (make check out to "Dan Riley") to: Adam's word, Dan Riley, Editor, 6 Cushing Street, 2nd floor, Waltham, MA. 02154.

ANOTHER FTM LEADER RETIRES

In a recent letter, Mario Martino, best known for his autobiography, Emergence, has informed FTM that, at age 52-1/2 he has retired from his service to the gender community and the Labyrinth foundation in New York. His contribution and presence will be sorely missed.

Mario joines several other FTM leaders, notably Rupert Raj and Jude Patton, who have recently opted to move on to other pursuits after many years of being there for the FTM community.

Our sincerest best wishes to Mario in all his future endeavors.

[THE PRECEEDING ARTICLES WERE REPRINTED FROM FTM NEWSLETTER.]

Work In Progress

BY SANDE ZEIG

(WATCH FOR MORE INFO. IN FUTURE ISSUES.- J.A.)

PRESCRIPTION MEDICINES THAT CAUSE HAIR LOSS:

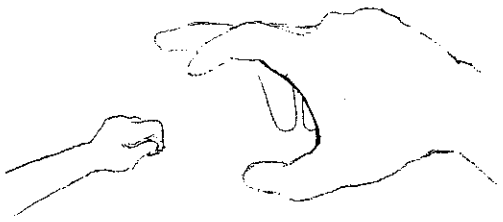
1.-Testosterone
2.-Seldane - Antihistimine
3.-Lopid - Cholesterol Lowering
4.-Acutaine - Acne treatment
5.-Tagamet/Zantac - Ulcer Medicine
6.-Blocadren, Inderal, Propanalol - Beta-Blockers
7.-Clinoril,Naprosyn,Indocin - Anti-inflammatory

THE FOLLOWING DOCTORS ARE CURRENTLY PERFORMING PHALLOPLASTY IN THE U.S.:

Dr. David Gilbert; Plastic Surgery Specialists, Inc. 400 Bramleton Ave. Suite 300, Norfolk, VA. 23510 (804) 622-7500

Dr. Donald Laub; Gender Dysphoria Program, Inc. 900 Welch Rd. Suite 402, Palo Alto, Ca. 94304

Dr. Stanley Biber; 406 First National Bank Building, Trinidad, Co. 81082 (719) 846-3301



— E. A. WALLACH.

10-13-89 FR

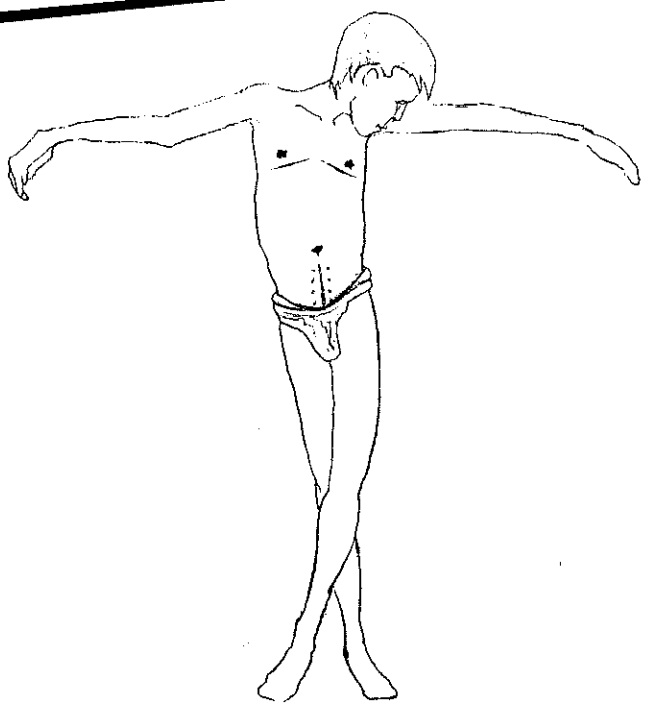
HE CROSSED THE ROOM AND STOOD BY THE WINDOW THAT WAS OPENED AJAR LETTING IN THE BRISK OCTOBER AIR. HE WAS WEARING OVERSIZED CLOTHS. A WOOL RAGLIN SLEEVE DARK TWEED COAT, UNDER WHICH HE WORE DOUBLE BLACK AND WHITE PATTERNED SHIRTS HUNG LOOSELY ABOUT HIM. UNDER THESE HE WORE A FADED BLACK T-SHIRT WHICH CLUNG TO HIS SMOOTH CHEST. HIS PANTS WERE WORN LOW ON HIS HIPS SHOWING THE DEPRESSIONS OF HIS PELVIS JUST ABOVE THE BELT WHICH IN LARGE BRASS LETTERS BORE THE WORD "BOY". HIS FADED 501'S WERE SO WORN THEY TOOK ON THE CONSISTENCY OF FLANNEL; HIS LEFT KNEE TORN TO HORIZONTAL THREADS. HIS DR. MARTINS WERE OPENED AT THE TOP, HELD ONTO HIS FEET ONLY BY AN IRON CHAIN AROUND ONE ANKLE AND A BANDANA ON THE OPPOSING ONE. HE HAD HIS HANDS HALF IN AND HALF OUT OF HIS POCKETS, LIKE HE WERE TRYING TO PRY THEM OPEN WITH HIS FINGERS. AT THE ANGLE I WAS LOOKING, I COULD SEE BEHIND HIS DARK WIRE FRAMED GLASSES HIS GREY EYES AND SLEEPLESS SHADOWED SOCKETS. HIS CURLY AUBURN HAIR, SHORT ON THE BACK AND SIDES HUNG FROM THE TOP OF HIS HEAD INTO HIS BABY FACE. HE LOOKED 13.

I SAW MYSELF ACROSS THE ROOM, 5 YRS. INTO MY FUTURE; AND THE MONEY I DON'T HAVE, SPENT ON THE SURGERY I NEED TO BE A MAN.

YOU SEE, I AM A FEMALE TO MALE PREOPERATIVE TRANSEXUAL, WHO IS AGAIN CONTEMPLATING SUICIDE. I MADE MY FIRST ATTEMPT WHEN I WAS 7½ YRS. OLD. SUCH IS LIFE ... AND DEATH.

HOW DO I FEEL ABOUT BEING A TRANSEXUAL? "I'M COLD, WEAK AND BITTER, LIKE THIS CUP OF COFFEE" COLD: LIKE A CORPSE, BEING ALMOST DEAD TO THE SENSATIONS OF ANGUISH AND MISERY OF NOT BEING ABLE TO SOLVE MY PROBLEM: AS I AM NOT WEALTHY. WEAK: FROM THE OPPRESSION OF LIVING MY LIFE AS HALF A PERSON, AND BITTER: FROM NOT ASKING TO BE BORN THIS WAY.

THERE IS NO QUESTION I WAS BORN THIS WAY.



A TRANSEXUAL MAKES HIS FIRST SUICIDE ATTEMPT AT AGE 7½ YRS. OLD AFTER BEING STONED BY OTHER CHILDREN.

TITLE:
HE WAS ONCE CALLED AN ANIGMA

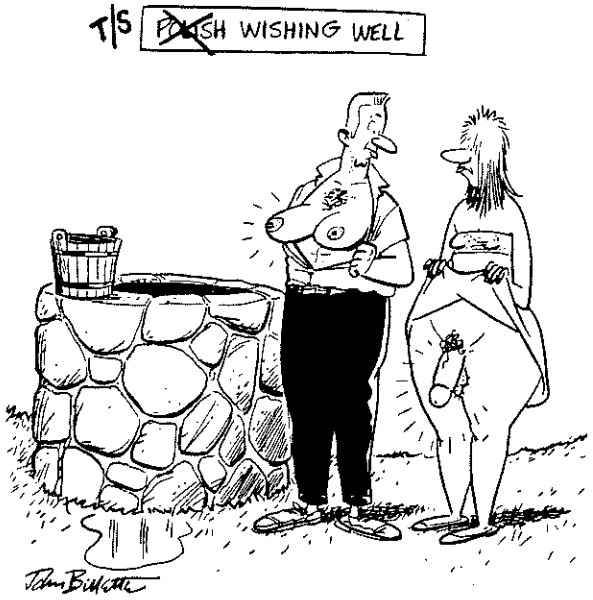
AN ABERATION.
ENCUMBERED SINCE BIRTH.
HE WAS ALWAYS THE OBSERVER
HIS SOUL IMPRISONED WITHIN
IT'S FLESHY VESSEL.
HE FELT THE DEPTHS OF
HIS NIGHTMARE CONTRADICTION
OF GENDER AND IDENTITY
HE REPULSED NO ONE BUT HIMSELF.
HE WISHED HE'D NEVER BEEN BORN.
IN A SHORT WHILE, AS SHORT AS
THIS CHILDS PATIENCE COULD BEAR
WITH TREMEROUS FIST HE WISHED HIMSELF DEAD
HE FELT MOCKED AND ALONE.
THE CHILD DID MAKE AN ATTEMPT,
A VALIANT ONE AT THAT AND FAILED
HIS BROTHER LIFTED HIS TINY
FROZEN AND INJURED BODY
AND BROUGHT HIM TO THE HOUSE
WHERE THEY LIVED
HE AWOKE IN SUCH PAIN AND SORROW
HE COULD NOT EVEN CRY
THEN HE FELL INTO SLEEP AND DREMPT
IF A MAN COULD ONLY FLEE HIMSELF
FREE HIMSELF
ACHIEVING THE TRUE SELF
HE DREMT OF ADAPTING HIS FLESH
TO HIS SOUL
HE DREAMPT OF BEING NEW
AND WHOLE.

— E. A. WALLACH

THE FOLLOWING ARTICLE WAS PRINTED IN THE 5/89 ISSUE OF "A ROSE NEWS" IN PHEONIX, AZ.

RECENTLY, I HAD THE PLEASURE OF MEETING AND SPENDING TIME WITH DR. STANLEY BIBER, THE WORLD RENOUNED GENDER SURGEON. HE HAS PERFORMED OVER 2,000 MALE-TO-FEMALE GENDER REASSIGNMENT SURGERIES OVER THE LAST 20 YEARS AND IS ONE OF THE MOST EXPERIENCED SURGEONS IN THIS FIELD. DURING OUR TIME TOGETHER, HE AGREED TO ANSWER SOME QUESTIONS THAT MIGHT BE OF INTEREST TO OUR COMMUNITY. WHAT FOLLOWS IS A TRANSCRIPTION OF THE INTERVIEW WHICH WAS CONDUCTED ON MAY 10TH AT MT.SAN RAFAEL HOSPITAL IN TRINIDAD, CO.

Wendi: when do you feel it's not justifiable to do this surgery?
Dr. Biber: Not Justified, well if a patient's dying from AIDS or something, we won't do the surgery. If the patient's not a true transsexual, of course we won't do the surgery, or if he's a schizophrenic, but ocassionally we'll do a patient who's gender problem is the cause of the schizophrenia, but boy, I'd have to have tremendous collaboration with the psychiatrists to really make sure what's going on but we've done a few, and we've had some good results with those...Either you fit the pattern or you don't get the surgery. That's the way it's got to be.
Wendi: Do you feel the surgery is justifiable for a patient who plans a gay lifestyle?
Dr. Biber: Yea, we didn't before, but several years ago we started dong them. We didn't really start, we got taken in...so little by little we came to believe, so what the hell, if there's homosexuality in the normal population, why shouldn't there be homosexuality in the transsexual population. So little by little we advanced and I don't hold it against them...we're still going to do them. We've had a few that came in and thought that they were gay, and after surgery they changed...they went straight. So there's variations, just like the natural population.
Wendi: Will you be continuing you're work in reassignment surgery in the foreseeable future?
Dr. Biber: We're going to try, it all depends,we're having a hell of a time with malpractice insurance with respect to transsexual surgery. Right now I'm actually going without insurance in order to do the transsexual work. This problem is scaring everybody else in the field. They just won't do it without insurance. That's the biggest bug-a-bo right now. In the future we don't know what's going to happen. Colorado just passed a law that says that in order to get a license to practice, you must get malpractice insurance or self-insure yourself. So it's very crazy right now until they sort through all that stuff. They run the world right now.
Wendi: How many female to male reassignments have you done?
Dr. Biber: Oh, off hand, right now we've been holding back most of those. We've been telling them that it's experimental, and if you can afford to wait, maybe we'll develop a better technique and we'll have it down. The ones that can't afford to wait, we tell them that it's experimental and are doing about 15 or so a year versus about 2 or 3 a week of the male to females
Wendi: How successful have the female to males been?
Dr. Biber: Not to, It's still experimental. Oh, we can make a penis look like a penis, it'll look like a penis, but it's not very functional. Not matter what technique you use there still got to be something better.
Wendi: Would you support a professional review system for surgeons that do reassignment surgery?
Dr.Biber: Well, that's kind of hard. You know that the transsexual community takes care of itself. The grape vine is so strong. They pretty well know which surgeons they should go to and which ones they shouldn't, and that's the best we can do at this time, otherwise we'd be interfering with the doctor patient relationship and that's a legal problem.
Wendi: What is your oppinion of the attitude of insurance companies toward reassignment surgery?
Dr. Biber: We've had all kinds of problems with insurance companies. Both from the malpractice (coverage) side and from the patient's side. Even so, there are some insurers that will cover the operation at the present time, most won't and we're not making a hell of a lot of a dent right now. As far as government insurance, medicare and medicaid, they won't accept the diagnosis. Certain states have bought it but general insurers are giving us a really hard time and are giving our patients a hard time too.
Wendi: Do you see that changing in the future?
Dr. Biber: I don't know, we may be hitting our heads against a stone wall, it's a matter of education. We need to educate the insurance companies like we've educated the psychiatrists, it's a syndrome now, and it's accepted. It took how many years, twenty some years. Oh, since '66 we've been trying and, I don't know how long it's going to take.
Wendi: It has been said that this type of surgery is on the increase, that 6 to 8 thousand surgeries have been done and that there are about 80 thousand candidates, do you agree with this?
Dr. Biber: I think we have a fairly good handle on the male to female. First we thought there were ten or twenty thousand in the United States and now we've got it up to bout 80 thousand. That's been pretty stable for the last few years. But what's coming out is the female to males, which we thought may be a one in ten ratio to the male to females. It's not. The communications that we're getting are that they are coming more and more and more. I bet that it's going to end up just the same.
Wendi: So you think it's going to be one to one?
Dr. Biber: Maybe, I bet you eventually, especially when we get the procedure perfected.
Wendi: This last question is meant to be answered from a philosophical viewpoint, why do you continue to do this surgery?
Dr. Biber: I have a great deal of empathy for the transsexual patients. I've seen so many, I know them so well respectively and I know what they're going through. I know how horrible it is, I mean, you kind of project yourself into the situation and how horrible it is for them to live their lives without being compilete. Actually, it's just like the frosting on the cake having surgery. But if I can do that for them, complete it for them and make them happy people, that's what I want. It's a matter of empathy. They're really great people when you come down to it, think what they've gone through. Oh, we've had patients who've given us a hell of a lot of trouble, but most of the patients are so nice, you know, they are real nice people...These people have gone through a lot of psychological stress, and if we can help them and make them good citizens, I like that.

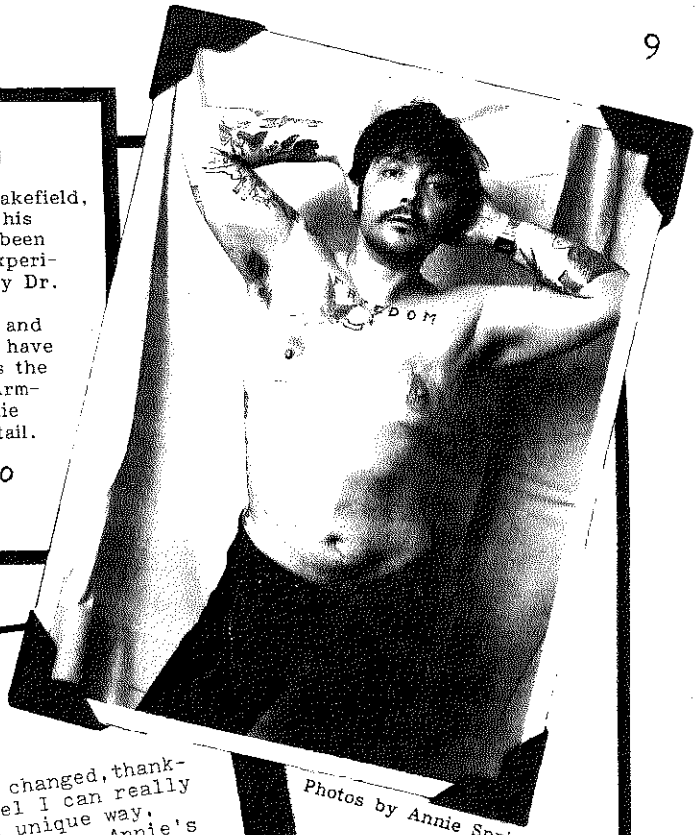


A LETTER FROM LES

Les Nichols is one of our new members. He lives in Wakefield, Mass., but manages to attend our socials. In fact, he met his fiance, Annie Sprinkle, at our last great event. They've been going hot and heavy, working and playing together, and experimenting with his new abdominal flap phalloplasty (created by Dr. Biber, in Trinidad, Colorado.)

Fortunately, Les is quite open about his transexuality and is happy to show off his operations. In fact, he and Annie have made a video movie called **LINDA/LES AND ANNIE**, which is the first female to male T/S love story. (Produced by John Armstrong, available through F2M.) In the video, he and Annie actually show how his man-made penis works in graphic detail.

LES APPEARS IN THE JANUARY AND FEBRUARY 1990 ISSUES OF HUSTLER MAGAZINE!



Photos by Annie Sprinkle

10/89

Dear R.O.P. Readers,

Since I've become a "complete" man, my life has really changed, thankfully, for the better! Now that I have my new phallus, I feel I can really express my love and affection for my girlfriend, Annie, in a unique way. Yes...you see...I kept my vagina and clitoris...but, not to worry, Annie's bisexual! Now I can hold her, and feel fulfilled, because I can physically extend all of my love right into her body. During intercourse, I don't need to touch my clitoris to climax, because of the constant friction and interplay of my testicles and **penis**. I feel like I'm a "normal Joe", with an ocean of incredible love that I'm ready willing and(now)ABLE to express. Now I can be one with Annie. I can see my penis penetrating her, just like in the porno movies...sometimes I have to pinch myself to make sure I'm not dreaming!!

I'm not shy about my body, like I used to be. I really like my body now, and I love to show it off! The almighty phallus is so revered in our society that I feel like my body is in demand! I like myself, and the new easier way I can make love to a woman. Annie never complains about the lack of foreplay (to "get it up") or the unromantic way I actually make it erect. I guess my staying power makes up for that.

I watched a fuck-film the other day, and I just couldn't wait to do the same act with Annie. I feel like life is so much more erotic. I feel like I've grown up...and matured somehow.

My phalloplasty is only a few months old. Annie was the first girl I tried it out with. At first it took some practice to keep it from flailing from side-to-side, but the more I practice "making whoopie" with this man-made equiptment, the more I think she loves me. She's one of the greatest lovers I've ever had, and the way she encompasses my manhood...it's like she becomes my whole world...it sounds like I'm in love, huh!?

This whole thing is such a miracle! Five or six years ago, when I was a VERY militant, radical lesbian feminist, I was full of anger at men. I envied their privaledge intensely. I was NOT well-adjusted! I just couldn't live as a woman in this oppressive patriarchal society. I had always had strong transsexual feelings, and all my therapists and doctors agreed that gender reassignment was a good idea for me. It may seem like a very radical form of therapy, but boy, it sure did work! Now I'm a happy caucasion male. But I must admit, as a STRAIGHT DUDE!!

I also never thought that I could be sexual without alot of S&M and kinkiness. But now I have an alternative, thanks to my enhanced libido, I'm just like all the other guys, getting hot over tits and ass! And I would have never believed that a beautiful, sexy, STRAIGHT woman would ever respect, and be turned-on to me as a MAN... and as a transsexual.

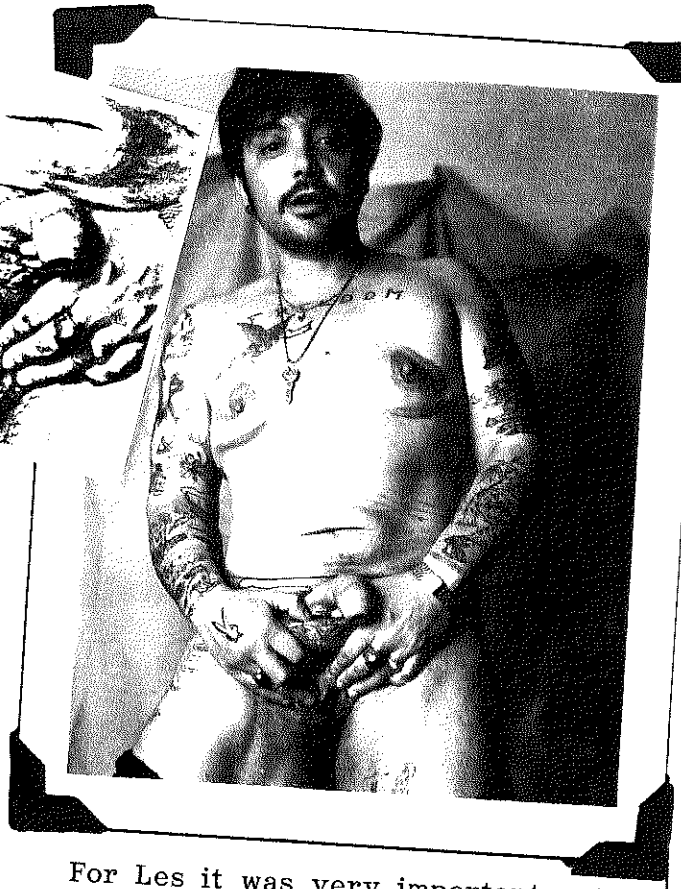
In closing, I MUST say, I want to thank my dear Mom, with all my heart, for allthe support, money and understanding!!

Respectfully Submitted,

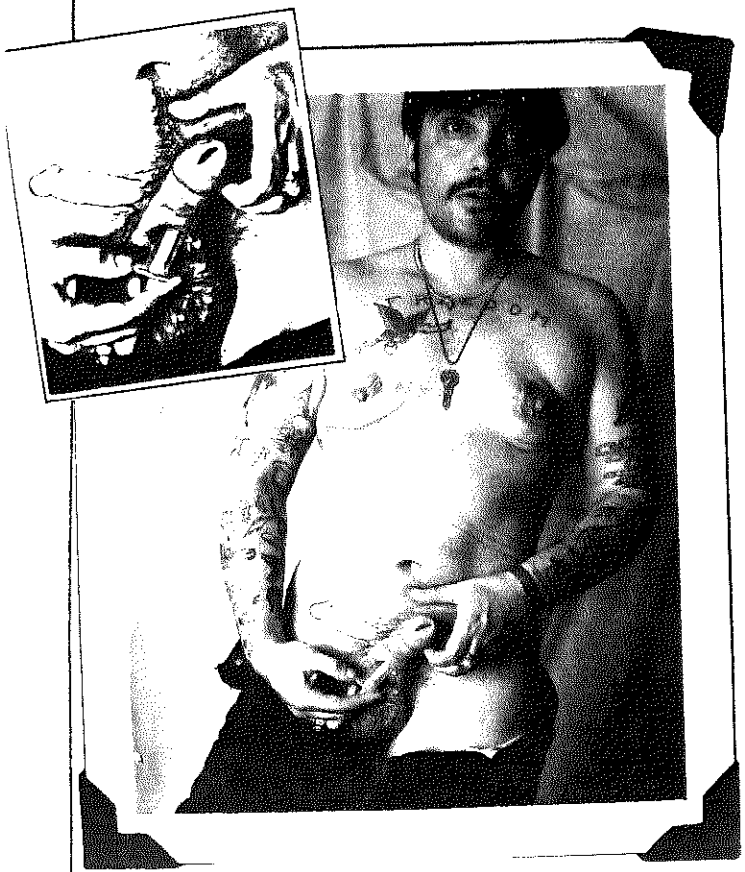
Les Nichols

P.S.- I've enclosed some snapshots.(It's great having a girlfriend who's a photographer.) At first I was gonna say that I hope no one is offended by my nudity, but if they're shocked I guess that's their problem!!!

Les Nichols proudly and uninhibitedly displays his new phallus and testicles. He's quite well hung, we see.



For Les it was very important not to loose any sexual sensitivity, so he kept his clitoris intact. The hormones have made it very enlarged. Now it's his "microphallus".



To get an erection, Les inserts a plastic tube in the center of his hollow penis. Now he can keep it erect for hours and hours and hours.

Photos by Annie Sprinkle

Les says that seeing the pleasure on his girlfriend Annie's face during intercourse, makes the pain of all twelve surgeries worthwhile

12 METHYLTESTOSTERONE TABLETS

SUBLINGUAL OR ORAL

DESCRIPTION: Each sublingual (10 mg) or oral (10 mg or 25 mg) tablet contains the label-stated dose of methyltestosterone, a synthetic androgen. Androgens are steroids that develop and maintain primary and secondary male sexual characteristics. Androgens are derivatives of cyclopentano-perhydrophenanthrene. In their active form, all drugs in this class have a 17-beta-hydroxy group. Endogenous androgens are C-19 steroids with a side chain at C-17, and with two angular methyl groups. Testosterone is the primary endogenous androgen. Methyltestosterone is a synthetic derivative of testosterone. 17-alpha-alkylation (methyltestosterone) increases the pharmacologic activity per unit weight compared to testosterone when given orally. The structural formula for methyltestosterone is:

CLINICAL PHARMACOLOGY: Endogenous androgens are responsible for the normal growth and development of the male sex organs and for maintenance of secondary sex characteristics. These effects include the growth and maturation of prostate, seminal vesicles, penis, and scrotum; the development of male hair distribution such as beard, pubic, chest, and axillary hair; laryngeal enlargement, vocal cord thickening, alterations in body musculature, and fat distribution. Drugs in this class also cause retention of nitrogen, sodium, potassium, phosphorus, and decreased urinary excretion of calcium. Androgens have been reported to increase protein anabolism and decrease protein catabolism. Nitrogen balance is improved only when there is sufficient intake of calories and protein. Androgens are responsible for the growth spurt of adolescence and for the eventual termination of linear growth which is brought about by the fusion of the epiphyseal growth centers. In children, exogenous androgens accelerate linear growth rates, but may cause a disproportionate advancement in bone maturation. Use over long periods may result in fusion of the epiphyseal growth centers and termination of growth process. Androgens are reported to stimulate the production of red blood cells by enhancing production of erythropoietic stimulating factor.
Exogenous administration of androgens inhibits endogenous testosterone release through feedback inhibition of pituitary luteinizing hormone (LH). At large doses of exogenous androgens, spermatogenesis may be suppressed through feedback inhibition of pituitary follicle stimulating hormone (FSH).
There is a lack of substantial evidence that androgens are effective in fractures, surgery, convalescence, and functional uterine bleeding.
Pharmacokinetics: Less extensively metabolized by the liver, and having a longer half-life, methyltestosterone is more suitable than testosterone for oral administration. Testosterone given orally is metabolized by the gut and 44% is cleared by the liver in the first pass. Oral doses as high as 400 mg daily are needed to achieve clinically effective blood levels for full replacement therapy.
Testosterone in plasma is 98% bound to a specific testosterone-estradiol binding globulin; about 2% is free. Generally, the amount of this sex-hormone binding globulin in the plasma will determine the distribution between the free and bound forms, and the free testosterone concentration will determine its half-life.
About 90% of a testosterone dose is excreted in the urine as glucuronic and sulfuric acid conjugates of testosterone and its metabolites; about 6% of a dose is excreted in the feces, mostly in the unconjugated form. Inactivation of testosterone occurs primarily in the liver. Testosterone is metabolized to various 17-keto steroids through two different pathways. There are considerable variations of the half-life of testosterone reported, ranging from 10 to 100 minutes.
In many tissues, the activity of testosterone appears to depend on reduction to dihydrotestosterone, which binds to cytosol receptor proteins. The steroid-receptor complex is transported to the nucleus where it initiates transcription events and cellular changes related to androgen action.

INDICATIONS & USAGE:
1. Males -- Replacement therapy in conditions associated with deficiency or absence of endogenous testosterone:
a) Primary hypogonadism (congenital or acquired)--testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome; or orchidectomy.
b) Hypogonadotropic hypogonadism (congenital or acquired) --idiopathic gonadotropin of LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation.
If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.
c) To stimulate puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every 6 months to assess the effect of treatment on the epiphyseal centers (see WARNINGS).
2. Females --
a) Breast cancer. Androgens may be used secondarily in women with advancing inoperable metastatic (skeletal) mammary cancer who are 1 to 5 years postmenopausal. Primary goals of therapy in these women include ablation of the ovaries. Other methods of counteracting estrogen activity are adrenalectomy, hypophysectomy, and/or anti-estrogen therapy. This treatment has also been used in premenopausal women with breast cancer who have benefited from oophorectomy and are considered to have a hormone-responsive tumor. Judgment concerning androgen therapy should be made by an oncologist with expertise in this field.
b) Management of postpartum breast pain and engorgement.

CONTRAINDICATIONS: Androgens are contraindicated in men with carcinomas of the breast or with known or suspected carcinomas of the prostate, and in women who are or may become pregnant. When administered to pregnant women, androgens cause virilization of the external genitalia of the female fetus. This virilization includes clitoromegaly, abnormal vaginal development, and fusion of genital folds to form a scrotal-like structure. The degree of masculinization is related to amount of drug given and age of the fetus, and is most likely to occur in the female fetus when the drugs are given in the first trimester. If the patient becomes pregnant while taking these drugs, she should be apprised of the potential hazard to the fetus.

WARNINGS:
In patients with breast cancer, androgen therapy may cause hypercalcemia by stimulating osteolysis. In this case, the drug should be discontinued.
Prolonged high dosage has been associated with the development of peliosis hepatis and hepatic neoplasms including hepatocellular carcinoma (see PRECAUTIONS--Carcinogenesis). Peliosis hepatis can be a life-threatening or fatal complication.
Cholestatic hepatitis and jaundice occur with 17-alpha-alkylandrogens at a relatively low dose. If cholestatic hepatitis with jaundice appears or if liver function tests become abnormal, the drug should be discontinued and the etiology should be determined. Drug-induced jaundice is reversible when the medication is discontinued.
Geriatric patients treated with androgens may be at increased risk of developing prostatic hypertrophy and prostatic carcinoma.
Edema, with or without congestive heart failure, may be a serious complication in patients with preexisting cardiac, renal, or hepatic disease. In addition to discontinuing the drug, diuretic therapy may be required.
Gynecomastia frequently develops and occasionally persists in patients being treated for hypogonadism.
Androgen therapy should be used cautiously in healthy males with delayed puberty. The effect on bone maturation should be monitored by assessing bone age of the wrist and hand every 6 months. In children, androgen therapy may accelerate bone maturation without producing compensatory gain in linear growth. This adverse effect may result in compromised adult stature. The younger the child the greater the risk of compromising final mature height.

PRECAUTIONS:
General: Women should be observed for signs of virilization (deepening of the voice, hirsutism, acne, clitoromegaly, and menstrual irregularities). Discontinuation of drug therapy at the time of evidence of mild virilism is necessary to prevent irreversible virilization. Such virilization is usual following androgen use at high doses. The patient and physician may decide that some virilization will be tolerated during treatment for breast carcinoma.

Information for the Patient: The physician should instruct patients to report any of the following side effects of androgens:
Adult or Adolescent Males: Too frequent or persistent erections of the penis.
Women: Hoarseness, acne, changes in menstrual periods, or more hair on the face.
All Patients: Any nausea, vomiting, changes in skin color, or ankle swelling.
Any male adolescent patient receiving androgens for delayed puberty should have bone development checked every six months.
Laboratory Tests:
1. Women with disseminated breast carcinoma should have frequent determination of urine and serum calcium levels during the course of androgen therapy (See WARNINGS).
2. Because of the hepatotoxicity associated with the use of 17-alpha-alkylated androgens, liver function tests should be obtained periodically.
3. Periodic (every 6 months) X-ray examinations of bone age should be made during treatment of prepubertal males to de-

THE BEST OF BOTH WORLDS SLVES by Jonny A.
{Themesong for "Linda/Les & Annie" Video}

1.- I WAS BORN UNDER A WILD SIGN, RAISED ON THE DARK SIDE OF LIFE,
HAD A LITTLE BIT O'GOOD LUCK, WHOLE LOTS O' BAD LUCK & STRIFE,
LOOK INTO MY EYES, BABY, TELL ME WHAT YOU SEE,
I'M A BIG MAN ON THE OUTSIDE, BUT Y'KNOW THIS HE WAS A SHE.
YEAH, I AM SO HARD & NASTY; BUT I'M SWEET-N-SASSY TOO,
BECAUSE I'VE GOT THE BEST OF BOTH WORLDS,
SO I'M ONE UP ON YOU; AN' I'M NEVER EVER BLUE!

2.- HAD A LOT O' LOVIN', DONE HAD A WHOLE LOT O' PAIN,
SOME SAY I'M SO SAINTLY, HELL, AN' SOME SAY I'M INSANE,
BUT I'M CRAZY LIKE A FOX, BABE, 'COZ' I KNOW JUST WHERE I STAND,
I HOLD THE WINNIN' HAND, NOW THAT I'VE BECOME A MAN.
YES I AM SO STRONG & SEXY, BUT I'M WARM & CARIN' TOO,
BECAUSE I'VE GOT THE BEST OF BOTH WORLDS,
SO I'M ONE UP ON YOU; AN' I'M NEVER EVER BLUE!

I GOT THE BEST O' BOTH WORLDS, I GOT THE BEST, I GOT THE BEST!
I AM THE BEST O' BOTH WORLDS, I AM THE BEST.!

New love pill makes women super sexy, say top doctors

WEEKLY WORLD NEWS
May 16, 1989 30587 70¢

It's an amazing love potion, say doctors

Male hormone is a turn-on for ladies

Pill makes them sexy and gives them more energy, study says

By SUSAN JIMISON

Forget the love potions and aphrodisiacs — what makes gals feel sexy is a pill containing the male hormone testosterone, a fascinating new study shows.

In research involving post-menopausal women, Dr. Barbara Sherwin of McGill University in Montreal found that the male hormone gave women more energy and more interest in sex than the female hormone did.

"Women receiving testosterone — either alone or with estrogen — had more sexual desire, more sexual fantasies and higher levels of sexual arousal then the women receiving no male hormone at all," said a report on Dr. Sherwin's study.

"The women on testosterone also had higher rates of intercourse and orgasm," said the report which appeared in *The Journal of the American Medical Association*. "It also gives women high energy levels and increases their sense of well-being."

Dr. Sherwin says pills that contain testosterone have been available for 25 years, but no one had done research to find out precisely what the effects of the hormone were. Some of the menopausal women were treated with the female hormone estrogen only, and these women complained of fatigue and a lack of interest in sex.

"Now we'll be able to fix a lot of the problems experienced by women after menopause," according to Dr. Sherwin. "There is a great interest in testosterone because of this study."

Still, many experts point out that doses of the male hormone might give women a greater tendency toward male characteristics such as a higher risk of heart disease. "And, of course, we don't want a lot of women growing beards," said Dr. Mitchell Harman, a testosterone expert at the National Institute of Aging in Baltimore.

"That would be another effect of too much testosterone."

DAN RILEY

DAN IS A FEMALE-TO-MALE CROSSDRESSER FROM MASSACHUSETTS. HE IS THE CO-FOUNDER OF THE ADAM SOCIETY, A SUPPORT GROUP FOR F.-TO-M.'S. HE IS ALSO THE EDITOR OF "ADAM'S WORD" NEWSLETTER.

Dear Editor,

It's been over a year now since I first attended a TV/TS support group. I was the only female crossdresser there, and the reactions ranged from pleasant surprise to curiosity, but there was always the overwhelming feeling of acceptance and warmth. The meeting was wonderful, and opened the door to new friends and experiences. I began to go "dressed" to meetings, and there was always acceptance and support. Things could not have been better... or so it seemed.

Slowly, I came to realize that the burden of self-acceptance was on my shoulders. The personal revelations that emerged were actively and consciously explore the masculine side of myself. Personal "stories" were shared and exchanged, and common ground was found. However, I was the only female, and try as I might to share myself with others and to understand them, there was a point beyond which meaninful conversation seemed lacking. The words I wanted to express would not surface, and the empathy I wanted to share could not be conjoured up like a white rabbit from a magician's hat. As much as I wanted to feel that I was "home" at my support meetings, something was missing. It was as though a member of my "family" was not there, and that absence left an emptiness in my heart and mind.

The "old" support group is still having their monthly parties, and their newsletter is still filled with events and articles which express their love and support for each other, but times have changed. I have joined a "new" group (I.F.G.E.). I now have continuous opportunities to offer back some of the love and support I so generously received from my home group. More importantly, in the process of offering that love and support I have found other female-to-male crossdressers and transsexuals, my "brothers", the missing members of my family.

My sense of community is more complete now. Slowly, as more opportunities to talk with other female CD's and TS's occur my feelings of aloneness disappear.

-Dan Riley

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Thanks to Christine-Jane Wilson for the cartoons

(REPRINTED FROM "TAPESTRY")

termine the rate of bone maturation and the effects of androgen therapy on the epiphyseal centers.
4. Hemoglobin and hematocrit should be checked periodically for polycythemia in patients who are receiving high doses of androgens.

Drug Interactions:
1. Anticoagulants: C-17 substituted derivatives of testosterone, such as methandrostenolone have been reported to decrease the anticoagulant requirements of patients receiving oral anticoagulants. Patients receiving oral anticoagulant therapy require close monitoring, especially when androgens are started or stopped.
2. Oxyphenbutazone: Concurrent administration of oxyphenbutazone and androgens may result in elevated serum levels of oxyphenbutazone.
3. Insulin: In diabetic patients, metabolic effects of androgens may decrease blood glucose and insulin requirements.

Drug/Laboratory Test Interferences: Androgens may decrease levels of thyroxine-binding globulin, resulting in decreased total T_4 serum levels and increased resin uptake of T_3 and T_4. Free thyroid hormone levels remain unchanged, however, and there is no clinical evidence of thyroid dysfunction.
Carcinogenesis:
Animal Data. Testosterone has been tested by subcutaneous injection and implantation in mice and rats. The implant induced cervical-uterine tumors in mice, which metastasized in some cases. There is suggestive evidence that injection of testosterone into some strains of female mice increases their susceptibility to hepatoma. Testosterone is also known to increase the number of tumors and decrease the degree of differentiation of chemically induced carcinomas of the liver in rats.
Human Data. There are rare reports of hepatocellular carcinoma in patients receiving long-term therapy with androgens in high doses. Withdrawal of the drugs did not lead to regression of the tumors in all cases.
Geriatric patients treated with androgens may be at an increased risk for the development of prostatic hypertrophy and prostatic carcinoma.
Pregnancy: Teratogenic Effects: Pregnancy Category X (See CONTRAINDICATIONS).
Nursing Mothers: It is not known whether androgens are excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from androgens, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Androgen therapy should be used very cautiously in children and only by specialists who are aware of the adverse effects on bone maturation. Skeletal maturation must be monitored every six months by an X-ray of hand and wrist (See INDICATIONS & USAGE, and WARNINGS).

ADVERSE REACTIONS:
Endocrine and Urogenital:
Female. The most common side effects of androgen therapy are amenorrhea and other menstrual irregularities, inhibition of gonadotropin secretion, and virilization, including deepening of the voice and clitoral enlargement. The latter usually is not reversible after androgens are discontinued. When administered to a pregnant woman, androgens cause virilization of external genitalia of the female fetus.

Male. Gynecomastia, and excessive frequency and duration of penile erections. Oligospermia may occur at high dosages (see CLINICAL PHARMACOLOGY).
Skin and appendages: Hirsutism, male pattern of baldness, and acne.
Fluid and Electrolyte Disturbances: Retention of sodium, chloride, water, potassium, calcium, and inorganic phosphates.
Gastrointestinal: Nausea, cholestatic jaundice, alterations in liver function tests, rarely hepatocellular neoplasms and peliosis hepatis (see WARNINGS).
Hematologic: Suppression of clotting factors II, V, VII, and X, bleeding in patients on concomitant anticoagulant therapy, and polycythemia.
Nervous System: Increased or decreased libido, headache, anxiety, depression, and generalized paresthesia.
Metabolic: Increased serum cholesterol.
Miscellaneous: Stomatitis with sublingual tablets; hypersensitivity and, rarely, anaphylactoid reactions.

OVERDOSAGE: There have been no reports of acute overdosage with the androgens.

DOSAGE & ADMINISTRATION:
The suggested dosage for methyltestosterone varies, depending on the age, sex, and diagnosis of the individual patient. Dosage is adjusted according to patient's response and appearance of adverse reactions. The following table is a guideline. Duration of therapy depends on indication, therapeutic response, and appearance of adverse reactions.

Indications	Daily Dosage Guideline Sublingual	Oral
Males		
Replacement therapy*.....	5-25 mg	10-50 mg
Females		
Breast cancer**.....	25-100 mg	50-200 mg
Postpartum breast pain & engorgement (for 3 to 5 days after delivery).....	40 mg	80 mg

*Various dosage regimens have been used to induce pubertal changes in hypogonadal males; some experts have advocated lower dosages initially, gradually increasing the dose as puberty progresses, with or without a decrease to maintenance levels. Other experts emphasize that higher dosages are needed to induce pubertal changes and lower dosages can be used for maintenance after puberty. The chronological and skeletal ages must be taken into consideration, both in determining the initial dose and in adjusting the dose. Dosages used in delayed puberty generally are in the lower ranges given in the table, and for a limited duration, for example, 4 to 6 months.
**Women with metastatic breast carcinoma must be followed closely because androgen therapy occasionally appears to accelerate the disease. Thus, many experts prefer to use the shorter-acting androgen preparations rather than those with prolonged activity for treating breast carcinoma, particularly during the early stages of androgen therapy.
Sublingual tablets: The effective sublingual dose of methyltestosterone is approximately one half that required when the drug is given orally. Sublingual tablets should not be swallowed since the hormone is meant to be absorbed through the mucous membranes. Place sublingual tablet under the tongue or in the upper or lower buccal pouch between gum and cheek. Avoid eating, drinking, chewing or smoking while the tablet is in place. Proper oral hygienic measures are particularly important after use of sublingual tablets.

HOW SUPPLIED:
Each compressed, single-scored, capsule-shaped, yellow tablet contains 10 mg of methyltestosterone for sublingual use.
Imprinted NDC 0115-3982.
Each compressed, single-scored, round, white tablet contains 10 mg of methyltestosterone for oral use.
Imprinted NDC 0115-3984.
Each compressed, single-scored, round, yellow tablet contains 25 mg of methyltestosterone for oral use.
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Bottles of 100 and 1000.
Store at controlled room temperature, 15°-30°C (59°-86°F).

CAUTION: Federal law prohibits dispensing without prescription.

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Here's why the sexes battle!

A new study pinpoints the prime sources of conflict between men and women and the results are guaranteed to surprise you.

According to University of Michigan psychologist David Buss, who conducted the research, here's what bothers a woman about a man:

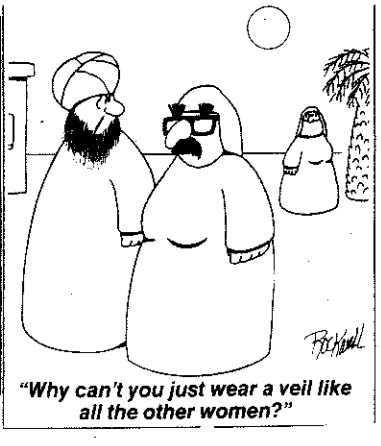
- Sexual aggressiveness.
- Condescension. Ignoring her opinions because she is a woman or treating her as inferior or stupid.
- Thoughtlessness. Being "unmannerly" by belching or leaving the toilet seat up.
- Hiding his emotions to act tough.
- Drinking or smoking too much.
- Neglect.

Here's what bothers a man about a woman:

- Moodiness, which is defined as a general "bitchiness" or otherwise being out of sorts.
- Sexual rejection.
- Self-absorption, a behavior that is characterized by a woman fussing over her appearance, fretting about her face or spending too much money on clothes.

Other major problem spots mentioned by both sexes are unfaithfulness and physical or verbal abuse, Dr. Buss said.

The expert based his findings on four different studies with nearly 600 women and men. In published reports, other researchers said that understanding the sources of trouble between women and men "could help soften the impact of persistent problems in relationships."



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GENDER STATUS: ☐Genetic Female. ☐Genetic Male. ☐Other:_____

☐Crossdresser: ☐Full time. ☐Part-time: ☐A little. ☐Alot.

☐Transsexual: ☐Pre-hormones. ☐Pre-Op. Date hormones were started: (Mo.) __/__ (Yr.).

☐Post-Op: ☐Hysterectomy. ☐Mastectomy. ☐Phalloplasty. ☐Genitoplasty.

☐Other:_____

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